PCN

Primary Care Network and Covered At Work

Bureau of Eligibility Services
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INTRODUCING
P. C. N.

Section 1

WHAT IS THE PRIMARY CARE NETWORK OF UTAH?

The Primary Care Network of Utah (PCN) is available to adults age 19-64 who are not eligible for any other Medicaid program, and have income under 150% of the federal poverty level (FPL). There is no asset test. Income is evaluated at the time of application, and at an annual review. No spenddown is allowed. An annual enrollment fee must be paid before an eligible individual or legally married couple can receive program coverage.

PCN includes **2 programs**, the Primary Care Network program and the Covered at Work program. Both programs have the same eligibility requirements except for an individual's access to employer-sponsored health insurance coverage.

1. **Primary Care Network Program (PC-P)**

   Limited scope of service program designed to provide basic primary care, emergency care and pharmacy services to uninsured adults who do not qualify for any other Medicaid category and who are not covered by or do not have access to affordable employer sponsored health insurance, student health insurance, Medicare or the Veterans Administration Health Care System.

2. **Covered at Work Program (PC-C)**

   Reimbursement payment program for uninsured adults who have access to and choose to enroll in an employer sponsored health insurance coverage and do not qualify for any other Medicaid category, student health insurance, Medicare or the Veterans Administration Health Care System. This program will pay a reimbursement check for the premium paid to cover an individual (up to $50/month) or married couple (up to $100/month) for employer-sponsored health insurance coverage for up to 5 years (60 months).

   An applicant must have employer-sponsored health insurance coverage available to them at a cost and cannot already be enrolled in the employee insurance.

General Eligibility Requirements

- Income equal to or below 150% of the federal poverty level.
- Age 19 through age 64.
- Not a full-time student.
- Not eligible for another Medicaid program. (May choose PCN if spenddown is required.)
- Not already enrolled in any kind of health insurance plan (other than Health Insurance Pool - HIP) including:
    - Medicare.
    - The Veterans Health Care System.
    - Employer-sponsored Health Insurance.
- Not eligible to enroll in:
    - Medicare.
    - The Veterans Health Care System.
    - Employer-sponsored Health Insurance if the cost to enroll is 5% or less of the household's countable gross income.
- Must pay an annual enrollment fee.

Primary Care Network Program Benefits

The Primary Care Network of Utah (PCN) is a medical assistance program designed to provide coverage for primary care services to many low-income adults.

Utah's philosophy under the PCN is to offer basic, limited coverage to low-income working adults until their income allows them to afford more complete coverage, or they become employed in a company that pays for a bigger share of their health care coverage.

Coverage

- Services by licensed physicians and other health professionals for primary care services only.
- Emergency services in hospital emergency room only.
- Lab and Radiology Services as part of primary care services.
- Medical equipment and supplies for recovery only.
- Ambulance (ground and air) for medical emergencies only. No non-emergency transportation.
- Basic dental services such as exams, preventative services, fillings and extractions.
- Vision screening. (Not eyeglasses)
- Pharmacy services limited to 4 prescriptions per month. No over the counter drugs.
- Family planning services consistent with physician and pharmacy services.

Recipients will be required to pay co-payments to the provider for some services.

- American Indian Primary Care Network recipients are not required to pay co-payments for services received through Indian Health Services or Tribal Health Care Systems if they live in one of the following counties:

    - Beaver, Box Elder, Carbon, Duchesne, Emery, Grand, Iron, Juab, Kane, Millard, Piute, San Juan, Tooele, Uintah, and Washington.

    - The ethnic code on PACMIS ETRC screen must be "AI" and the residential address must include one of the above counties.

Covered At Work Program Benefits

The Covered At Work program provides a reimbursement for all or part of the insurance premium paid by an employee for their employer-sponsored health insurance plan.

No Medicaid Benefit and No Medicaid Card

♦ Reimbursements

- A monthly reimbursement check will be sent to the household.
- Reimbursements will not exceed the amount paid for each individual.
- Reimbursements will be limited to a lifetime maximum of 60 months for each individual.

♦ Reimbursement Amounts

- Per Individual

# Years Eligible Covered at Work	Reimbursement Monthly Amount
1	up to $50
2	up to $50
3	up to $40
4	up to $30
5	up to $20

- A married couple could be reimbursed up to $100 total per month. (Up to $50 each.)

BASIC PCN ELIGIBILITY

Section 2

BASIC ELIGIBILITY

IIIF Section 900

GENERAL REQUIREMENTS THAT APPLY TO ALL MEDICAID PROGRAMS *(SUCH AS CITIZENSHIP, SOCIAL SECURITY NUMBER, ETC.)* MUST BE MET, ALONG WITH THE SPECIFIC REQUIREMENTS FOR PCN.

♦ Application Pathway/Process

- An application for PCN consists of a properly completed PCN application or any approved BES/DWS application form.
- The date of application is the date a completed and signed application form is received.
- The same policy in Volume IIIF Section 703 regarding the application process applies to PCN.
- Applications will only be accepted during open enrollment periods.

♦ Effective Date of Coverage

- Eligibility for PCN begins with the date a completed and signed application is received. NOTE: Eligibility does not go back to the first day of the application month.
    - For Covered at Work, an applicant must pay a premium for employer-sponsored health insurance in the month to be eligible. If they do not pay an insurance premium in the month of application the application effective date would be the first day of the month they start to pay an insurance premium.

Example: Jimmy applied for PCN on August 21. He has access to employer-sponsored health insurance coverage and qualifies for the Covered at Work program. He enrolls in the employer coverage, however, it will not begin until September 9, when the first premium payment will be deducted from his check. The effective date of eligibility for Jimmy is September 1.

- **NO RETROACTIVE COVERAGE IS ALLOWED.**
    - Consider other Medicaid programs for retroactive coverage.

♦ Medicaid Eligible

Consider any other Medicaid program an individual could qualify for prior to the Primary Care Network Program.

- An individual who qualifies for any other Medicaid program without a spenddown is not eligible for the PCN program. An individual who must spenddown to become eligible may choose not to spenddown and can be considered for PCN.

DM APPLICATION

A person claiming a disability may be opened (if eligible) on PCN while the disability determination process is being conducted. Once the disability is established, approve DM (if eligible) back to the original application date.

Educate the applicant and give them the "Medicaid for those with Disabilities and the Primary Care Network (PM962)" and the "Disability Medicaid (PM984)" brochures .

- An applicant must provide information necessary to determine eligibility for other Medicaid programs.
    - Do not proceed with a PCN eligibility determination if the applicant fails to provide information needed to determine Medicaid.
- If it is clear that the applicant does not meet the requirements for any other Medicaid program, do not request verification that does not apply to PCN requirements. (IE: The applicant does not meet any other adult category or their assets are over the limit for regular Medicaid program, etc.)

If an individual qualifies for another Medicaid program without a spenddown, OPEN the other Medicaid Program.

DO NOT CONSIDER PRIMARY CARE NETWORK ELIGIBILITY FOR THAT INDIVIDUAL.

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If an individual is NOT eligible for any Medicaid Program, OR is only eligible for a Medicaid Program with a spenddown and chooses not to spenddown...

DETERMINE ELIGIBILITY FOR THE PRIMARY CARE NETWORK.

♦ Age

An individual must be at least age 19 and under age 65.

- If Medicaid eligible the month of their 19th birthday, open Medicaid.
- If open CHIP leave CHIP open through the end of the month of their 19th birthday. Consider PCN for the following month.
- If not Medicaid eligible the month of their 19th birthday, consider CHIP if they apply before their actual birth date. If they apply after their actual birth date, consider PCN.
- Not PCN eligible if application date is on or after their 65th birthday.
- If not Medicaid eligible, may be PCN eligible through the end of the month of their 65th birthday.

♦ Ineligible Aliens

PCN does not allow coverage for emergency services ('E' coverage group) for ineligible aliens. An individual must meet U.S. citizenship or qualified alien requirements to be eligible.

♦ Income Standards

Countable gross income must be equal to or less than 150% of the federal poverty level for the household size.

♦ Asset Standards

There is NO ASSET TEST for PCN.

- Consider assets only when determining if the applicant would be eligible for a Medicaid program.

♦ TPL

TPL questions on the application or the form 19 must be completed. The Primary Care Network program usually will not have insurance coverage, but could be covered under a Limited Coverage Insurance Plan which would require a referral.

- For the Covered at Work program, provide information regarding employer-sponsored health insurance coverage to ORS based on the regular TPL pathway. ORS will verify the insurance and notify us if they drop or lose coverage.

♦ Medical Support Enforcement

Duty of Support is not required for PCN. However, if a person is being sanctioned from a Medicaid program for non-compliance, they are not eligible for PCN.

♦ Enrollment Fee

An enrollment fee is required for both the Primary Care Network program and the Covered at Work program and must be paid at application and at each 12 month review before any benefit can be authorized.

- For recipients with income below 50% of the poverty income level, the annual enrollment fee is $25.
- For recipients receiving cash assistance under the General Assistance Program through The Department of Workforce Services, the annual enrollment fee is $15.
- For all other recipients, the annual enrollment fee is $50.

HEALTH INSURANCE COVERAGE

Section 3

Health Insurance Coverage

Sec. 903

Generally the eligibility requirements are the same for the Primary Care Network Program and the Covered at Work Program. The main difference between the two programs is that the Covered at Work program is specifically for individuals who have access to employer-sponsored health insurance.

If a person has access to employer-sponsored health insurance coverage, they may be eligible for the Covered at Work Program and in some cases the Primary Care Network Program depending on the cost of coverage.

Individuals who are already enrolled in a health insurance plan (other than Health Insurance Pool - HIP) or individuals who have access to certain types of health insurance are not eligible for PCN.

♦ Terms You Should Know

The following are Terms you should know.

Employer-Sponsored Health Coverage or Plan - an employee benefit plan that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

Health Insurance Coverage or Plan - A benefit plan offered by a health insurance issuer which provides for coverage of medical care under any hospital or medical service plan contract, or health maintenance organization contract. The coverage may be a group insurance plan or an individual insurance plan. A health insurance issuer is a company licensed to sell insurance under state law.

Limited Coverage Plans - Insurance plans which only provide medical care for a single type of service or specific disease, under special or specific circumstances, or where the medical care is secondary to the primary purpose of the insurance. The following are examples of limited coverage plans:

- Limited scope dental or vision benefits.
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
- Coverage only for a specified disease or illness such as cancer.
- Worker's Compensation or similar insurance.
- Coverage only for accident or disability income insurance, or any combination thereof.
- Hospital indemnity or other fixed indemnity insurance. (Example: plans which pay a fixed daily rate to the individual for inpatient stays.)
- Coverage for on-site medical clinics.
- Liability insurance, including general liability insurance and automobile liability insurance.
- Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.
- Credit-only insurance, which pays a loan payment during a period of incapacity or disability.
- Coverage issued as a supplement to liability insurance.

Medical Care - Amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; transportation primarily for and essential to medical care, and amounts paid for insurance covering medical care.

Pre-existing Condition Exclusion Period - A time period during which the plan will not cover services for a person related to a pre-existing medical condition. A pre-existing medical condition exclusion period cannot exceed 12 months (in some cases 18 months) and may be reduced if the individual had recent prior coverage under an insurance plan or a medical program such as Medicaid.

Open Enrollment Periods - The times a person may enroll in the plan if he or she did not enroll at the earliest possible time. New employees and their dependents, usually must enroll in the employer's plan within a certain time period after starting a new job. After that, there is usually one time period during a year to enroll in the plan.

Waiting Period - A period of time that must pass before an individual who is enrolled in an insurance plan can receive coverage for services under the plan. For example, the individual may enroll in the insurance plan on their first day of employment, but coverage under the policy does not start until the first day of the next month.

- A waiting period is not a period of time that an employer requires the person to be employed before they are allowed to enroll in a group health insurance plan. For example, an employer who requires their employees to work for them for six months before they are eligible to enroll in the insurance.

COBRA Coverage - A temporary extension of employer health insurance coverage whereby a person who loses coverage under the employer's group health plan can remain covered for a certain length of time. The person is usually required to pay both the employee and the employer share of the premium, with up to an additional 2% for administrative costs.

Student Health Insurance Plan - A health insurance plan that is offered to students directly through a college, university or other educational facility or through private health insurance companies that offer coverage plans specifically for students.

Health Insurance Pool (HIP) - A state health insurance pool that provides coverage for high-risk individuals who are unable to obtain coverage in the marketplace.

Health Insurance Coverage Rules

♦ ENROLLED in a Health Insurance Plan

Individuals who are ENROLLED in health insurance coverage (other than Health Insurance Pool - HIP) are not eligible for the Primary Care Network program or the Covered at Work program. This includes anyone who is ENROLLED in a employer-sponsored health plan or other health insurance coverage through which they have not exhausted their maximum lifetime benefits.

- Effective January 2005, a person enrolled in the Health Insurance Pool (HIP) can be eligible for the Primary Care Network or Covered at Work programs.

Examples -

- → Employer-sponsored plan through an employer or spouse's employer.
- → Parent's or legal guardian's health insurance plan.
- → Part A and/or B Medicare.
- → Veterans Administration Health Care System.
- → Student health insurance plan.
- → Any other type of group or individual health insurance plan that is not HIP or limited coverage.

- If the plan provides "medical care" and is not a "limited coverage plan", it is health insurance, and the person is not eligible for the PCN.

- Limited Coverage Insurance plans which only provide <u>some</u> medical care for a single type of service or specific disease, do not make a person ineligible for PCN. ***<u>Note: A TPL referral may be required if a person has a limited plan.</u>***

- A person who has been signed up for a plan that provides "medical care" is enrolled even if they are subject to a pre-existing condition exclusion period or the plan has a waiting period for benefits.

A Person Who Has Coverage for Medical Care Under Indian Health Services May Be Eligible for the PCN.

♦ ACCESS to Certain Types of Health Insurance Coverage

Individuals who have **ACCESS** to but are not enrolled in the following types of health insurance coverage are not eligible for the Primary Care Network program or the Covered at Work program.

- **Medicare -** Part A and/or B, no matter what the cost.

- **Veterans Administration Health Care System -**

  - Veterans who have not already enrolled in the Veterans Health Care System, may be eligible for the Primary Care Network program or the Covered at Work program while they are waiting for determination from the VA. They must initiate the enrollment procedure with the VA before they can be eligible for PCN. Once enrollment in the VA Health Care becomes effective, they are no longer eligible.

  - Veterans who are not eligible for enrollment in the VA Health Care System may remain eligible for PCN.

- **Student Health Insurance -** available to full-time students.

  - Full-time students who can enroll in a student health insurance plan are not eligible for PCN. The student health insurance plan may be offered directly through the university or other educational facility or through private health insurance companies that offer coverage plans specifically for students. If the student's spouse is not a full-time student; is not enrolled and has not voluntarily terminated health insurance coverage within 6 months of the PCN application; they may be eligible for PCN even though the student health plan offers coverage for dependents.

    - ***Applicants:*** If an applicant is not attending school full-time on the date of application, but expects to start attending school full-time at some point after the date of application, they can be eligible for PCN only until they begin attending school full-time and can enroll in a student health insurance plan.

      CLOSE THE PCN CASE AS SOON AS THEY BEGIN ATTENDING SCHOOL AND CAN ENROLL IN A STUDENT HEALTH INSURANCE PLAN. 10 DAY NOTICE RULE APPLIES.

    - ***Recipients:*** If a household currently authorized for PCN reports that a PCN recipient has become a full-time student who can enroll in a student health insurance plan, discontinue PCN coverage for that student.

      CLOSE THE PCN COVERAGE AS SOON AS THE RECIPIENT BEGINS ATTENDING SCHOOL AND CAN ENROLL IN A STUDENT HEALTH INSURANCE PLAN. 10 DAY NOTICE RULE APPLIES.

♦ ACCESS to Employer Sponsored Health Insurance

Depending on the cost of coverage and the household income, some individuals who have ACCESS to employer-sponsored health insurance may be eligible for the Covered at Work program and in some cases the Primary Care Network program.

Cost of Coverage

Amount the employee is required to pay, over and above any contribution from the employer, to enroll himself or his spouse in the employer-sponsored health insurance coverage.

Consider only the cost to enroll the person who is applying for PCN benefits. If both spouses are applying, consider the cost of coverage for each one separately.

- Determine the total monthly cost for the individual to enroll that is over and above any contribution from the employer.
- When determining the total cost for the spouse of an employed person, include the cost to cover the employed person if he or she must be enrolled in order to enroll the spouse.
- Compare the total cost of coverage for each individual to the household's countable gross income to determine a percentage.

Formula

Cost of Coverage ÷ Household Income = %

For individuals who have **ACCESS** to health insurance coverage through their employer or their spouse's employer, determine eligibility as follows:

- **5% or Less** - Cost of coverage does not exceed 5% of the household's countable gross income - not eligible for the Primary Care Network program or the Covered at Work program.

- **>5% -15%** - Cost of coverage is MORE THAN 5% but does NOT EXCEED 15% of the household's countable gross income - only eligible for the Covered at Work program if they choose to enroll in the employer-sponsored coverage.

    - ***Note:*** They are not eligible for Covered at Work until the month they enroll in the employer-sponsored coverage.

- **>15%** - Cost of coverage EXCEEDS 15% of the household's countable gross income - during Primary Care Network program open enrollment periods an individual may choose to enroll in either the Primary Care Network program or the Covered at Work program. If they choose:

    - To ENROLL in the Covered at Work program, they must enroll in the employer-sponsored coverage. They are not eligible for Covered at Work until the month they enroll.

    - NOT TO ENROLL in their employer-sponsored coverage, Primary Care Network program may be approved.

A person eligible to enroll in employer-sponsored coverage is considered to have access even if they must wait until an open enrollment period.

CWEC Screen Will Calculate

Cost of Coverage Examples

Example 1: Mr. Hansen lives alone and is applying for the PCN. He is employed and his employer offers health insurance. The total cost of the health insurance is $150 per month. The employer would deduct $25 a check from Mr. Hansen's earnings if he elects to enroll in the health coverage. Mr. Hansen is paid every other week and his gross income is $500 each check.

Monthly Cost to Enroll Mr. Hansen $25 x 2.15 =	$ 53.75
Monthly Gross Countable Income - $500/ck x 2.15=	$ 1075.00
% of the Gross Income (PACMIS will calculate %)	5.00%

Mr. Hansen's cost to enroll in employer-sponsored health insurance does not exceed 5% of the household's gross countable income. Mr. Hansen is not eligible for the Primary Care Network program or the Covered at Work program.

Example 2: Mrs. Davis is applying for the PCN. Her husband's employer pays for his coverage, but to add her to the coverage, the employer would deduct $25 from his weekly pay check. Mr. Davis gross income is $395 a check. Mr. Davis is not eligible for PCN because he is enrolled in health insurance coverage.

Mrs. Davis' Cost to Enroll - $25 x 4.3 =	$ 107.50
Monthly Countable Income for Household - $395 x 4.3 =	$1698.50
% of the Gross Income for Mrs. Davis (PACMIS will calculate)	6.32%

Mrs. Davis' cost to enroll in employer-sponsored health insurance is more than 5% but does not exceed 15% of the household's gross countable income. Mrs. Davis would be eligible for the Covered at Work program.

Example 3: Mr. and Mrs. Johnson are applying for PCN. He is employed and his employer offers health insurance coverage but he has not enrolled. Mr. Johnson gets paid twice a month and the employer would deduct $70 per check for him and an additional $75 per check to include his spouse. Mr. Johnson receives $750 gross income per check. Mrs. Johnson cannot enroll unless her husband enrolls.

Mr. Johnson's Cost to Enroll - $70 x 2 =	$ 140.00
Monthly Countable Income for Household - $750 x 2 =	$1500.00
% of the Gross Income for Mr. Johnson (PACMIS will calculate)	9.33%

Mr. Johnson's cost to enroll in employer-sponsored health insurance is more than 5% but does not exceed 15% of the household's gross countable income. Mr. Johnson would be eligible for the Covered at Work program.

Mrs. Johnson's Cost to Enroll - $70 + $75 x 2 =	$ 290.00
Monthly Countable Income for Household - $750 x 2 =	$1500.00
% of the Gross Income for Mr. Johnson (PACMIS will calculate)	19.33%

Mrs. Johnson's cost to enroll in employer-sponsored health insurance exceeds 15% of the household's gross countable income. Mrs. Johnson can choose to enroll in either the Primary Care Network program or the Covered at Work program. ***Note:*** *if Mrs. Johnson could be enrolled, even if Mr. Johnson (the employed person) chooses not to enroll, her cost of coverage would be $75 x 2 = $150/mo.* ***Note:*** *To be eligible for the Covered at Work Program Mrs. Johnson must enroll in the employer-sponsored coverage.*

♦ Other Information About Employer Insurance

▸ Cafeteria or Flexible Benefit Plans

Some employers may allow a certain dollar amount per employee to "purchase" various kinds of benefits, including health insurance. Each employee has some discretion in how to use his "benefits." For example, an employer may allow a certain amount each month that could be used to purchase group health insurance, additional life insurance, long-term disability benefits, etc. If the employee has these funds available, is allowed to use them to purchase health insurance, and the employer offers a group health plan, consider the amount allowed as the employer contribution in determining cost of coverage.

- ➢ If an employer pays cash to employees with the intent that the employees privately purchase individual health insurance, the funds paid by the employer are simply counted as income.

- ➢ In some instances, employees may choose to defer some income from gross pay to be used to reimburse the employee for out-of-pocket medical expenses. This type of benefit is usually called a "flex-plan" or "flexible spending plan." This is different than funds the employer makes available to the employee to purchase health insurance. Do not deduct deferred income for medical expenses from the employee's wages.

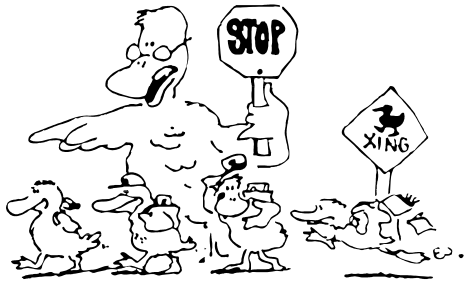
♦ Out of State Health Insurance Coverage

A person may be eligible for PCN if the insurance plan they are enrolled in is from another state and does not provide coverage or provides only limited coverage in Utah. If the out of state plan provides coverage in Utah, the person is not eligible for the PCN.

Example: Jerry age 20, came to Utah from Idaho to go to work. His job does not offer health insurance. Jerry is listed on his parents health insurance in Idaho but the insurance plan only covers emergency room services in Utah. Jerry could be eligible for PCN because his insurance is limited coverage.

♦ Termination of Health Insurance Coverage

Voluntary Termination - With a few exceptions, a person is NOT eligible for PCN if he or she has voluntarily terminated health insurance coverage within 6 months before applying for PCN. Count from the date the prior insurance coverage ended and the person may be eligible beginning the day after the 6 month period ends.



Keep your ducks in a row and do not voluntarily terminate your insurance coverage!

- **No 6 Month Sanction Occurs** when there is VOLUNTARY TERMINATION of:

    - COBRA coverage.
    - State Health Insurance Pool (HIP).
    - Coverage by a parent.
    - Coverage by a spouse who is not living in the same household as the applicant.

    Example: *Jenny voluntarily terminated her health insurance coverage on March 15. She would be sanctioned until September 15. Jenny could become PCN eligible beginning September 16.*

- A person who is on the Covered at Work program who voluntarily terminates their employer-sponsored health insurance coverage is not eligible for a PCN program for 6 months from the date the coverage ended.

Involuntary Termination - There is no sanction for an applicant who is involuntarily terminated from health insurance coverage. If an applicant has been terminated from a job or has quit a job, and loses health insurance as a result, consider the loss of health insurance as involuntary termination. Purchase of available COBRA coverage is NOT REQUIRED.

- A person who is on the Covered at Work program who involuntarily loses the employer-sponsored coverage is no longer eligible for the Covered at Work program and may switch to the Primary Care Network program.

♦ Eligibility When an Employer's Health Insurance Plan Becomes Available

Applicants

During a Primary Care Network program open enrollment an applicant or their spouse whose employer offers health insurance but there is a period of time that must pass before they are eligible to enroll, the applicant and/or their spouse may be eligible for the Primary Care Network program until they are eligible to enroll in the employer-sponsored health insurance plan.

> ***Example:*** *The person was hired on 6/10/02 but is not eligible for benefits until they have been with the company for 90 days.*

- When the employer-sponsored insurance becomes available, redetermine eligibility for the Primary Care Network program or the Covered at Work program as follows:

  - If they choose to enroll, they may switch to the Covered at Work program if the cost of coverage exceeds 5% of the gross countable income.

  - If they choose not to enroll and the cost of coverage does not exceed 15%, they are no longer eligible for the Primary Care Network program.

  - If the cost of coverage does not exceed 5% of the household's gross countable income, they are not eligible for either the Primary Care Network program or the Covered at Work program. It does not matter if they choose to enroll.

Note: If it's not an open enrollment period, the person cannot receive the Primary Care Network coverage.

Recipients

When a recipient of PCN or their spouse begins employment during the certification period and the employer offers health insurance coverage, determine continued eligibility as follows:

- If they choose to enroll and report it within 10 days, they may switch to the Covered at Work program if the cost of coverage exceeds 5% or the household's gross countable income.
    - Do a new 12 month best estimate to figure cost of coverage but do not do a new income eligibility determination until the next scheduled recertification.
- If they did not report within 10 days that they chose to enroll, they cannot switch to the Covered at Work program. Close the Primary Care Network case.
- If they choose NOT to enroll they may remain on Primary Care Network program until the end of the certification period.
    - At the next certification, all factors of eligibility must be considered, including income eligibility and cost of coverage.

♦ When Other Types of Insurance Become Available During the Certification Period

Recipients of the PCN programs are no longer eligible when they:

- Become a full-time student and can enroll or are eligible to enroll in a **STUDENT HEALTH INSURANCE** plan.
- Become enrolled in or eligible to enroll in Part A or B **MEDICARE**.
- Become eligible and are accepted for enrollment in the **VA HEALTH CARE SYSTEM**.
    - A recipient must initiate the process to enroll as soon as they become eligible to enroll. They may remain on PCN until their enrollment becomes effective. If they refuse to initiate the enrollment process close the PCN program.
- Enroll in any other type of **HEALTH INSURANCE** coverage.

Notes:

INCOME ELIGIBILITY DETERMINATION

Section 4

Income

Sec. 904

COUNT ONLY THE INCOME OF THE APPLICANT AND THEIR LEGAL SPOUSE.

♦ Countable Income

Sec. 904-1

Follow regular Medicaid income rules found in IIIF Sections 400-407 regarding income and income exclusions. Apply those rules to PCN with the following exceptions:

- **DO NOT COUNT** income of a spouse under the age of 19 unless they are the head of the household.
  - Accept client statement as to who is head of household.
- **DO NOT COUNT** income of a dependent child under the age of 19.
- **COUNT** the SSI payment and any other countable income of an applicant's SSI spouse.
  - DO NOT count the income of an SSI spouse under age 19 who is not head of household.
- **COUNT** General Assistance cash payments (from DWS).
- **DO NOT ALLOW** any income deductions or disregards when determining the countable earned or unearned income for PCN.

Best Estimates

Sec. 904-4

BUDGET INCOME PROSPECTIVELY FOR THE 12 MONTH CERTIFICATION PERIOD.

Eligibility is determined prospectively at the time of application and renewal for the upcoming 12 month certification period using a best estimate of income.

- Establish a new best estimate only at application, renewal, or when the household reports a decrease in income which could make them eligible for Traditional Medicaid.

- Compute a best estimate by using the household's average monthly income which is expected to be received or made available to the household during the upcoming 12 month certification period. If income is received less often than monthly, you may compute the average annual amount that will be received, and prorate it over the certification period.

    - Do Not Count income that was received prior to the month of application.

    - Do Not Count income that has terminated, even if the last payment will be received after the date of application.

    - If an income change is expected, but the amount is unknown, do not use it when computing the best estimate.

- Methods of computing the best estimate are income averaging, income anticipating, or income annualizing. A combination of methods may be used to obtain the most accurate best estimate. The best estimate may be a monthly amount that is expected to be received each month of the certification period, or an annual amount which will be prorated over the certification period.

    - Annualize income that is received sporadically or under contract or at irregular intervals throughout the year.

- Income that is received weekly or every other week must be factored to a monthly amount. (4.3 for weekly income or 2.15 for every other week income.)

Once the best estimate is established, reduce it to a monthly amount and compare it to 150% of the poverty level for the household size.

♦ Document the Best Estimate 904-5

Clearly document on CAAL or in the case record the:

- Methods used in determining the best estimate;
- Calculations and the amounts agreed upon with the applicant; AND
- Anticipated income changes used in the best estimate determination.

Best Estimate Example

Mr. Jones is employed and earns $7.00 per hour. He works 30 hours per week and is paid weekly. He says he could be eligible for a raise but nothing is certain. Since we cannot anticipate any change of his hourly wage for sure, we would figure his income as follows. $7.00 X 30 X 4.3 = $903 per month. Since he expects no other income or changes it is not necessary to convert to an annual amount and reduce back to a monthly amount. Enter $903 on the EAIN screen in the CHIP/PC column.

His wife is receiving unemployment benefits. On the unemployment interface screen it shows that she has $789 left in her UC benefit account. The total income anticipated from this source for the next twelve months is $789. Reduce this to a monthly amount, $789 ÷ 12 = $65.75. Enter $65.75 on the UNIN screen in the CHIP/PC column.

Household Size

904-3

♦ Who Must Be Included in the PCN Household Size

- The following individuals who <u>reside together</u> **MUST** be counted in the PCN household size, even if they do not meet U.S. citizenship or qualified alien status requirements:

  - The applicant.
  - The legal spouse of the applicant.
  - Any children or step-children (son or daughter) of the applicant who are under age 19.
  - An unborn child if the applicant or the legal spouse of the applicant is pregnant.

- **<u>DO NOT COUNT</u>** the following individuals in the household size:

  - A person living in the household with whom the applicant has a child or children in common but who is not the applicant's legal spouse.

  - Any child or unborn child of the applicant's children who are included in the household size.

  - A spouse of the applicant's children who are included in the household size.

  - If an individual is caring for a child of his or her former spouse and a divorce has been finalized, do not include that child in the household size.

If household partners are not legally married, set them up on separate PC cases. Any children they have in common can be counted in both households. The unmarried partner of an eligible PC client is not included in the household size.

♦ Temporary Absence

- Include an individual who is temporarily out of the home when:

  - Absence is caused SOLELY by active duty in the military.
  - Absence is caused SOLELY by employment, school, training, or medical treatment.
  - Absent parent will return home within 30 days from the date of application.

♦ SEPA Coding

IN, OU, DM, OC and UB are the only participation codes allowed for PCN. Do not us the 'SS' code for an SSI child or spouse.

- IN — Primary client (PI) and legal spouse ONLY. Their income will count and they will be included in the household size and the benefit.

- IN or DM — Legal spouse of the applicant. Their income will count and they will be included in the household size; however, they will not be included in the benefit. ***If the spouse is under age 19 and not head of household, code them DM, but do not post their income.***

- OC — All children or step-children (son or daughter) of the applicant who are under age 19. They are included in the household size, but not included in the benefit. Their income will not count. ***Note: A child who does not meet qualified alien status may be coded 'OC'.***

- UB — Unborn child of an adult who is coded 'IN' or 'DM' for the PC program. The unborn will be included in the household size. After birth, if the relationship code for the newborn is UB, leave the participation code UB. If the newborn's relationship code is CH, use the OC participation code.

SEPA CODES

Participation Code	Individual	Included in PCN Benefit?	Counts Them in Household Size?	PACMIS Count's Their Income?
IN	(PI) Adult or Legal Spouse (SP) **ONLY**	Yes	Yes	Yes
DM	(PI) Adult or Legal Spouse (SP) **ONLY**. ***** Code a spouse under the age of 19 DM, but do not post their income in the CHP/PC field unless they are head of household.***	No	Yes	Yes
OU	Person not included in household. *IE: Children who are age 19 or over.*	No	No	No
OC	Child (CH) or Stepchild (SC) under age 19. ***** Citizenship status of the child is not a factor.***	No	Yes	No
UB	Unborn child of an adult coded IN or DM **or** newborn that must keep UB relationship code.	No	Yes	No

*****Never use the 'SS' code for PCN.***

Income Limit

Sec. 904

- Compare the countable gross income to 150% of the federal poverty guidelines for the household size.
  - If the household's income exceeds 150% of the federal poverty guidelines for the household size, the household is not eligible for PCN.
  - If the household's income is equal to or less than 150% of the federal poverty guidelines for the household size, the household has met income eligibility.

PCN MONTHLY INCOME TABLE

Income Limits Household Size	150% of Poverty Guidelines April 2004
1	$1164
2	$1562
3	$1959
4	$2357
5	$2754
6	$3152
7	$3549
8	$3947
9	$4344
10	$4742

Examples:

1. Joe and Jill are legally married and have 2 children, Jack and Joan. Joan is the only person who qualifies for Medicaid (NB+).

   A. How many cases would you need to set up, and why?

   B. Opening PCN for Joe, Jill and Jack, and NB+ for Joan, how would you SEPA code each person's participation? (Use the grid below.)

Program ➜				
Joe (age 48)				
Jill (age 46)				
Jack (age 20)				
Joan (age 18)				
Household Size=				

2. Sam and Sue are not married, however, they have a child in common named Sally.

   A. How many cases would you need to set up, and why?

   B. Opening PCN for both Sam and Sue and NB for Sally, how would you SEPA code each's person's participation?

Program ➜				
Sam (age 25)				
Sue (age 23)				
Sally (age 3)				
Household Size=				

   C. Sam and Sue both have income, how does it count?

3. Leon and Noel are married and expecting their first child.

A. Noel is eligible for PN and Leon is eligible for PCN. How would you SEPA code each's person's participation?

Program ➜	PN	PC
Leon (age 22)		
Noel (age 20)		
Unborn		
Household Size=		

B. Noel is not PN eligible; but is PG eligible with a spenddown. The unborn is not due for 5 more months, so she chooses not to spenddown at this time. You are opening both Leon and Noel on PCN. How would you SEPA code each's person's participation?

Program ➜	PC
Leon (age 22)	
Noel (age 20)	
Unborn	
Household Size=	

4. Mike and Michelle are married. Living with them are their 17 year old daughter Mickie (who is pregnant) and her 1 year old son Mitchell. Mike and Michelle are not Medicaid eligible. Michelle has health insurance coverage. You are opening PCN for Mike, NB for Mitchell and PN for Mickie and her unborn child. How would you SEPA code each's person's participation?

Program ➜	PC	NB	PN
Mike (age 50)			
Michelle (age 47)			
Mickie (age 17)			
Mitchell (age 1)			
Unborn (Mickie's)			
Household Size=			

5. Russell and Daria are married and have 3 children, Jay, Joey and Kimberly. Daria and Jay do not meet U.S. citizen or qualified alien criteria. You are opening PCN, NB and CHIP (not NB+ eligible). How would you SEPA code each's person's participation?

Program ➜	PC	NB	CHIP
Russell (age 41)			
Daria (age 40)			
Jay (age 16)			
Joey (age 12)			
Kimberly (age 4)			
Household Size=			

6. Tim and Christine are married and have 1 child, Missy. Tim is receiving SSI ($250/mo) and is eligible for Disabled Medicaid (DM) with no spenddown. Christine & Missy are only FM eligible with a spenddown because of Christine's income $1000/mo). They choose not to spenddown. You are opening DM, PCN, and NB+. How would you SEPA code each's person's participation and what would your monthly income best estimate be for PCN?

Program ➜	DM	PC	NB
Tim (age 32)			
Christine (age 29)			
Missy (age 8)			
Household Size=			

7. Mork (age 20) and Ork (age 18) were just married last month. Mork is attending a technical school that does not offer health insurance coverage. Ork is working and making $850 each month. You are opening PCN and NB+.

   A. What question must be answered before you know whether or not to count Ork's income for PCN?

   B. How would you SEPA code each's person's participation?

Program ➜	PC	NB+
Mork (age 20)		
Ork (age 18)		
Household Size=		

   C. Ork will turn age 19 three months after the PCN opens. What action will you take then?

Example Answers:

1. Joe and Jill are legally married and have 2 children, Jack and Joan. Joan is the only person who qualifies for Medicaid (NB+).

   A. How many cases would you need to set up, and why? **2 cases because Jack (age 20) must be on his own PCN case.**

   B. Opening PCN for Joe, Jill and Jack, and NB+ for Joan, how would you SEPA code each person's participation? (Use the grid below.)

Program ➜	PC (parents)	NB+		PC (Jack)
Joe (age 48)	IN	DM		OU
Jill (age 46)	IN	DM		OU
Jack (age 20)	OU	OU		IN
Joan (age 18)	OC	IN		OU
Household Size=	3	3		1

2. Sam and Sue are not married, however, they have a child in common named Sally.

   A. How many cases would you need to set up, and why? **2 cases because Sam and Sue are not married. Sally may be included in the household size of each case.**

   B. Opening PCN for both Sam and Sue and NB for Sally, how would you SEPA code each's person's participation?

Program ➜	PC (Sam)	NB		PC (Sue)
Sam (age 25)	IN	DM		OU
Sue (age 23)	OU	DM		IN
Sally (age 3)	OC	IN		OC
Household Size=	2	3		2

   C. Sam and Sue both have income, how does it count on PCN? **Their income only counts on their own case. (Sam's counts on his case; Sue's counts on her case.)**

3. Leon and Noel are married and expecting their first child.

A. Noel is eligible for PN and Leon is eligible for PCN. How would you SEPA code each's person's participation?

Program ➜	PN	PC
Leon (age 22)	DM	IN
Noel (age 20)	IN	DM
Unborn	IN	UB
Household Size=	3	3

B. Noel is not PN eligible; but is PG eligible with a spenddown. The unborn is not due for 5 more months, so she chooses not to spenddown at this time. You are opening both Leon and Noel on PCN. How would you SEPA code each's person's participation?

Program ➜	PC
Leon (age 22)	IN
Noel (age 20)	IN
Unborn	UB
Household Size=	3

4. Mike and Michelle are married. Living with them are their 17 year old daughter Mickie (who is pregnant) and her 1 year old son Mitchell. Mike and Michelle are not Medicaid eligible. Michelle has health insurance coverage. You are opening PCN for Mike, NB for Mitchell and PN for Mickie and her unborn child. How would you SEPA code each's person's participation?

Program ➜	PC	NB	PN
Mike (age 50)	IN	OU	DM
Michelle (age 47)	DM	OU	DM
Mickie (age 17)	OC	DM	IN
Mitchell (age 1)	OU	IN	DM
Unborn (Mickie's)	OU	UB	IN
Household Size=	3	3	5

5. Russell and Daria are married and have 3 children, Jay, Joey and Kimberly. Daria and Jay do not meet U.S. citizen or qualified alien criteria. You are opening PCN, NB and CHIP (not NB+ eligible). How would you SEPA code each's person's participation?

Program ➜	PC	NB	CHIP
Russell (age 41)	IN	DM	DM
Daria (age 40)	DM	DM	DM
Jay (age 16)	OC	DM	DM
Joey (age 12)	OC	DM	IN
Kimberly (age 4)	OC	IN	DM
Household Size=	5	4	5

6. Tim and Christine are married and have 1 child, Missy. Tim is receiving SSI ($250/mo) and is eligible for Disabled Medicaid (DM) with no spenddown. Christine & Missy are only FM eligible with a spenddown because of Christine's income $1000/mo). They choose not to spenddown. You are opening DM, PCN, and NB+. How would you SEPA code each's person's participation and what would your monthly income best estimate be for PCN?

Program ➜	DM	PC	NB
Tim (age 32)	IN	DM	SS
Christine (age 29)	DM	IN	DM
Missy (age 8)	OU	OC	IN
Household Size=	1	3	2

7. Mork (age 20) and Ork (age 18) were just married last month. Mork is attending a technical school that does not offer health insurance coverage. Ork is working and making $850 each month. You are opening PCN and NB+.

   A. What question must be answered before you know whether or not to count Ork's income for PCN? **Who is head of the household? If Mork is the head of household, Ork's income would not count. If not, Ork's income would count.**

   B. How would you SEPA code each's person's participation?

Program ➜	PC	NB+
Mork (age 20)	IN	DM
Ork (age 18)	DM*	IN
Household Size=	2	2

*If Mork is head of household; Ork would be coded DM on PCN but exempt or do not post her income.

   C. Ork will turn age 19 three months after the PCN opens. What action will you take then? **If Ork is not Medicaid eligible and meets all other qualifications (IE: does not have health insurance) add her to the PCN case with Mork without counting her income, until the end of the certification period. At review, establish a new best estimate which includes her income.**

ENROLLMENT FEE

Section 5

Enrollment Fee

Sec. 906

Once it has been determined that an individual or legally married couple meet the eligibility requirements for the PCN, an enrollment fee must be paid before any coverage can be authorized.

- Recipients receiving cash assistance under the General Assistance Program through The Department of Workforce Services, must pay an annual enrollment fee of $15.

- Compare the countable income on the PCIE screen to the 50% poverty income level (Table XIII). If the recipient's income is below 50% of poverty, they must pay a $25 enrollment fee.

- All other recipients of the Primary Care Network program or Covered at Work program must pay a $50 annual enrollment fee.

  - One enrollment fee covers an individual or a legally married couple for the full twelve month certification period.

  - The enrollment fee must be paid at the time of the initial application and at each 12 month review.

  - The enrollment fee must be paid within 30 days of the mailing date of the notice.

  - If the enrollment fee is not paid within the required time frame, deny the application or review.

  - A recipient does not have to pay another enrollment fee during the 12 month period if the PCN program closes and is reopened before the end of the month following the closure.

  - A recipient does not have to pay another enrollment fee when their eligibility changes from PCN to Medicaid and then back to PCN with no break in coverage within the same 12-month certification period.

  - An enrollment fee that has already been paid covers an eligible spouse added to the PCN coverage until the next regular recertification.

  - A new enrollment fee is not required when a recipient switches from one PCN program to another during the certification period.

  - None of the enrollment fee will be refunded if the PCN case closes before the end of the twelve month certification period.

How to Manually Determine the PCN Enrollment Fee

PACMIS will eventually be programmed to determine the amount of the enrollment fee. However, for now manually determine the amount that each PCN household must pay.

1. Compare the countable income on the PCIE screen to the 50% poverty income level. (See InfoSource Table XII.)
   - Individuals or couples with income below 50% of poverty will pay a $25 enrollment fee
   - Individuals or legally married couples who receive cash assistance under the General Assistance Program through the Department of Workforce Services will pay a $15 enrollment fee.
   - All other individuals or couples will pay a $50 enrollment fee.

2. Enter the appropriate enrollment fee amount on the PCN approval notice.

The GIPC notice is used to inform the client that the enrollment fee is required.

- Do not send the GIPC notice to people who have access to employer-sponsored coverage at a cost of more than 15% and may choose either the Primary Care Network program or the Covered at Work program until they have made their choice. If their choice is to:
  - Enroll in the Primary Care Network program send the GIPC notice.
  - Enroll in the employer-sponsored coverage, verify the date they enrolled in the employer coverage before requesting payment of the enrollment fee.
    - ➢ Change the date of application to the date they enrolled in the employer coverage.
    - ➢ Send the GIPC notice.

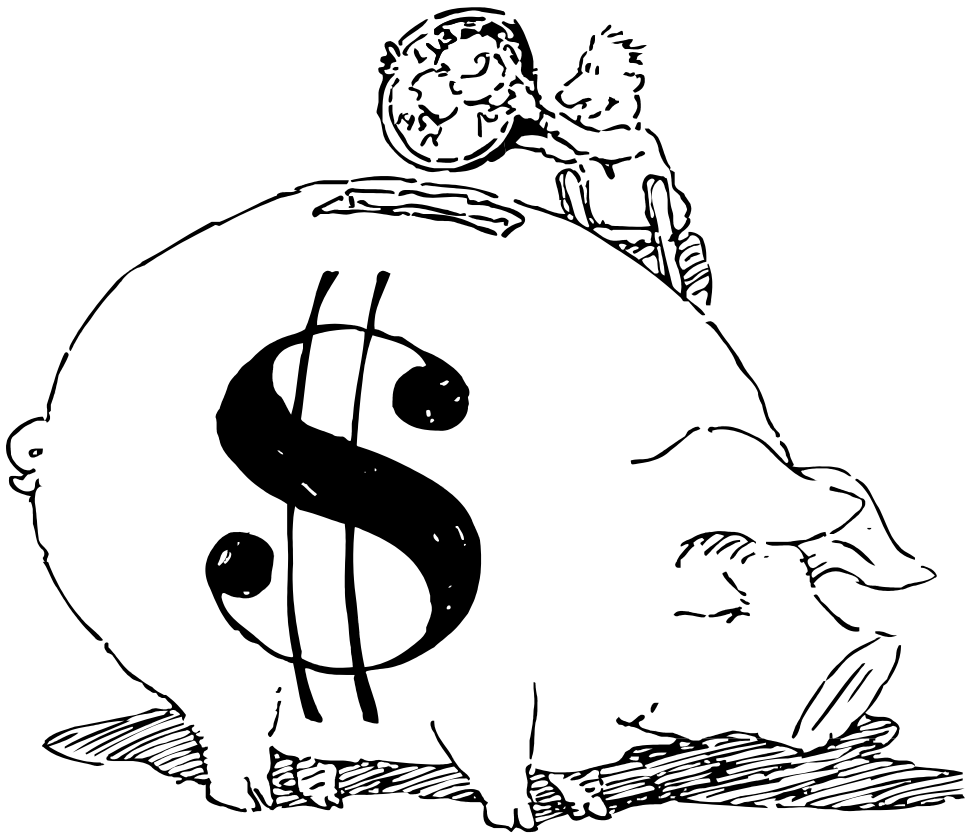
Document on the CAAL screen which amount the household must pay and enter that amount on the GIPC notice when the eligibility determination is made. Business office workers will look at the CAAL screen or the notice to determine how much they should collect when the PCN client comes in to pay the enrollment fee.

♦ Process for Payment of the Enrollment Fee

- Eligibility must be determined, but not authorized until the fee is paid. You must enter through the PCIE screen before the fee can be paid. The authorization field is protected until the enrollment fee is paid. Edit message will read “IS ELIGIBLE, MUST PAY ENROLLMENT FEE”.

- Fee may be paid at the same locations where the spenddown is collected. (IE: business office, etc.)

- Once the payment has been entered by the business office, the authorization field on PCIE will allow you to authorize PCN.



CHANGES

Section 6

Change Reporting

Sec. 909

PCN only requires action on certain reported changes. Evaluate any reported change to determine if it could affect PCN eligibility.

♦ The following changes **MUST** be reported to the local office within 10 days of the day the client learns of the change.

▸ If a recipient household member of either the Primary Care Network program or the Covered at Work program:

- Moves to a new address within the state.
- Moves out of the household or dies.
- Moves out of state.
- Enters a public institution.
- Begins to be covered by or gains access to:
  - ✓ Medicare.
  - ✓ Veteran's Health Care System.
  - ✓ Student Health Insurance Coverage (becomes a full-time student).
- Enrolls in any other type of Health Insurance coverage, (other than employer-sponsored or Health Insurance Pool -HIP).

▸ If a recipient household member of the Primary Care Network program:

- Becomes covered by or gains access to Employer-Sponsored Health Insurance Coverage.

▸ If a recipient household member of the Covered at Work program:

- Loses Employer-Sponsored health insurance coverage.
- Changes insurance plans.
- Is required to pay a different premium amount for their employer-sponsored health insurance coverage.

♦ No other changes are required to be reported during the certification period. However, if a change is reported, it must be acted upon.

♦ Take action on information received from other sources, IE: Interface matches, etc.

When ANY change is reported, ALWAYS determine if a PCN recipient has become Medicaid eligible.

Other Changes

- **Income Changes** are not required to be reported by recipients of the PCN program during the certification period. However, when a change in income is reported by the recipient or the eligibility worker becomes aware of an income change through another reliable source, take action on the change as follows:

  - **Increase In Income -** Do not redetermine income eligibility if income increases during the recertification period. Set an alert for the recertification month to consider the reported change at that time.

  - **Decrease In Income** - When a reported income change makes a PCN recipient eligible for Medicaid without a spenddown, immediately remove the person from PCN (or close the PCN case) and open Medicaid. Do not wait for recertification.

Asset Changes
There is no asset test for PCN.
However, asset changes may make
a PCN recipient eligible for Medicaid.

Household Changes

♦ Adding A Spouse

******Both spouses do not have to be on the same PCN program.******

- During PCN open enrollment periods, a legally married spouse may be added to an open PCN case during the certification period if one of the following applies:

  - PCN individual gets married during the certification period.

  - Spouse was not in the home at the time of application, then returns to the home.

  - Spouse was included in a PCN program at the time of application, but lost eligibility and then again becomes eligible during the certification period.

  - Spouse was not eligible for PCN at the time of application because of enrollment in or access to another Health Insurance Plan or because of a sanction for voluntary termination of Health Insurance but would now be eligible.

  - At the time of the PCN application, the spouse had access to employer-sponsored coverage and would have been eligible for the Covered at Work program but they could not enroll in the coverage until the following month or until an open enrollment period.

  - Spouse was eligible for a Medicaid program at the time of application and is no longer eligible for Medicaid or no longer wants to spenddown to be eligible.

- Eligibility Requirements - A new income eligibility determination is not necessary when adding a spouse. The spouse may be added to PCN coverage for the remainder of the certification period if they meet the following requirements. They are:

  - Legally married.
  - Within the age requirements for PCN.
  - Not eligible for a Medicaid program or eligible for Medicaid with a spenddown but chooses not to meet the spenddown.
  - Are not covered or do not have access to coverage under a Health Insurance Plan and have not voluntarily terminated coverage as described in the Health Insurance Section of the training packet or Vol. IIIF Section 903.

- Effective Date of Coverage

  - Use the date of request when adding a spouse to PCN coverage.

Remember **- Add a spouse for the remainder of the certification period and:**

- Do not do a new income determination.
- Spouse must meet all other eligibility requirements for one of the PCN programs.
- Effective date = date of request.
- No new enrollment fee.

♦ Removing an Ineligible Person or Closing an Ineligible Case.

- When a change makes a person ineligible for PCN, remove that person from the coverage (code them 'DM'), or close the PCN case.

- Determine if the individual is eligible for any other Medicaid program.

♦ Reopening PCN When a Recipient Has Been Eligible for Medicaid if There Has Been No Break in Coverage Between PCN and Medicaid.

- Same Certification Period. If the recipient meets all eligibility requirements other than income and was:

  - Open for the Primary Care Network program reopen the person on the Primary Care Network program for the remainder of the certification period.

  - Open for Covered at Work program and still has employer health insurance coverage, reopen Covered at Work.

  - Open for the Covered at Work program and no longer has employer coverage reopen the recipient on the Primary Care Network program.

    DO NOT:

    - ➢ Reopen if there has been a break in coverage between PCN and Medicaid.
    - ➢ Require a new application;
    - ➢ Do a new income determination; OR
    - ➢ Collect a new enrollment fee.

  - A review is required at the end of the certification period.

- Certification Period Has Expired.

  - Complete an new eligibility determination, including income, but do not require a new application.

  - If PCN eligible, collect a new enrollment fee and authorize a new 12 month certification period.

IF A MARRIED COUPLE WERE BOTH PCN RECIPIENTS AND ONLY ONE OF THEM CHANGED TO A MEDICAID PROGRAM, FOLLOW PROCEDURES FOR ADDING A SPOUSE.

♦ PCN/Medicaid Is Closed for a Full Benefit Month.

*****A new application can only be accepted if it is an open enrollment period.*****

When a PCN case closes and the individual is not covered for PCN or Medicaid for a full benefit month, he or she must reapply. Complete a new eligibility determination with a new best estimate of income over the next 12 months. If they are found eligible for PCN, collect the enrollment fee and authorize a new 12 month certification period.

IF A MARRIED COUPLE WERE BOTH PCN RECIPIENTS AND ONLY ONE OF THEM BECAME INELIGIBLE FOR A PCN PROGRAM OR MEDICAID PROGRAM FOR ONE FULL BENEFIT MONTH OR MORE, FOLLOW PROCEDURES FOR ADDING A SPOUSE.

♦ Married Couples Who Separate During the Certification Period.

If a married couple both receiving PCN coverage on the same case separate, they both may remain PCN eligible. Remove the spouse who is out of the home from the open case and open a new case for that person for the remainder of the certification period.

- At the end of the certification period, both individuals will be required to complete a review and pay the enrollment fee for the new certification period, if they remain eligible.

♦ Case Closure & Notification

Proper notice must be given for any negative action or case closures. Follow notification policy found in IIIF Section 811**.**

CERTIFICATION PERIOD

Section 7

Certification Period

PCN Certification = 12 Months

♦ The certification period for the PCN program is 12 months. The application month is not counted in the first certification period.

<u>Exceptions</u> - Eligibility may end prior to 12 months if the recipient:

- Moves out of state.
- Enters a public institution.
- Dies.
- **Becomes Eligible**:
  - To enroll in Medicare.
  - For coverage through the Veterans Administration Health Care System.
  - For student health insurance because they become a full-time student.
  - For another Medicaid program.
- **Is On the Primary Care Network Program and:**
  - Enrolls in an employer-sponsored health insurance plan and the cost of coverage does not exceed 5% of the household's gross countable income.
  - Enrolls in any type of health insurance coverage that is not employer-sponsored.
- **Is On the Covered at Work Program and**
  - The amount of the premium for the employer-sponsored coverage drops below 5% of the household's gross countable income.

- **When to Establish a New 12 Months of Eligibility**

  - When a recipient completes the recertification process, is determined eligible, and pays a new enrollment fee.

  - When the PCN case closes and there is no coverage under PCN or Medicaid for one full benefit month or more, the individual must reapply. A new 12-month certification period will be assigned if the applicant is determined eligible and pays a new enrollment fee.

Do not extend a certification period beyond 12 months.

♦ **When Not to Establish a New 12 Months of Eligibility**

  - When a recipient's eligibility changes from PCN to Medicaid and then back to PCN with no break in coverage within the same 12-month certification period.

  - When another program is reviewed or added to the PCN case.

  - When a recipient switches from one PCN program to another during the certification period.

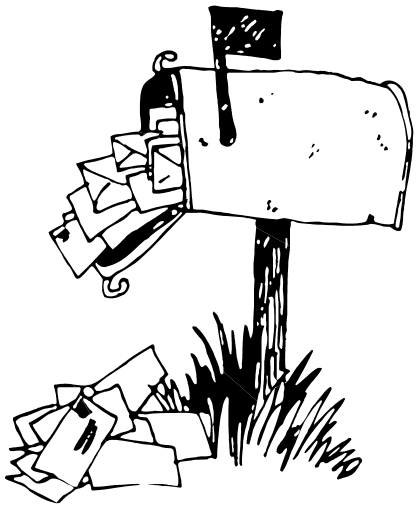
All factors of eligibility must be reviewed at the end of the original 12 month certification period.

12 Months

♦ Review Process

Complete a review at the end of the 12 month certification period.

- Screen the information on the review to determine if any individual may qualify for Medicaid.
    - Remove any person from PCN, or close the PCN case and open Medicaid for anyone who is eligible.
    - Proceed with the PCN review if no one is eligible for Medicaid.
- Review all PCN eligibility factors including:
    - Enrollment in or access to any kind of health insurance coverage.
    - New income best estimate for the next 12 months.
- If eligible, send the GIPC notice to request payment of the enrollment fee.
- Once the enrollment fee is paid, authorize a new 12 month certification period.



COVERED AT WORK REIMBURSEMENTS

Section 8

Covered At Work Reimbursements

- Reimbursement checks for up to $50 per individual will be issued by the Health Department through the FINET system around the 10th and 20th of every month. Payments will not show on PACMIS.

  - An individual is eligible for Covered at Work benefits for a lifetime maximum of 60 months. The maximum monthly payment decreases by $10 after the 2nd year of coverage and the $10 every year thereafter.

    - The Health Department will notify the case manager when an individual's reimbursement will be decreased and/or when they reach their lifetime maximum.

  - On the 5th of each month, the Dept. of Health receives a report of all Covered At Work benefits that have been authorized, the amount of the insurance expense (EC) that was posted on the EXPE screen, and the number of months a benefit has been issued. The report is run again on the 20th and will show all benefits that have been authorized on or after the 5th of the month. These reports are used by the Health Department to issue the checks.

  - To see whether a benefit was authorized, go to MEBH. A Covered at Work benefit will show as PC-CW.

  - The checks for the 5th of the month report will be sent to the enrollee sometime between the 10th and the 20th of the benefit month. Checks for the 20th of the month report will be sent to the enrollee sometime between the 25th of the benefit month and the 5th of the following month.

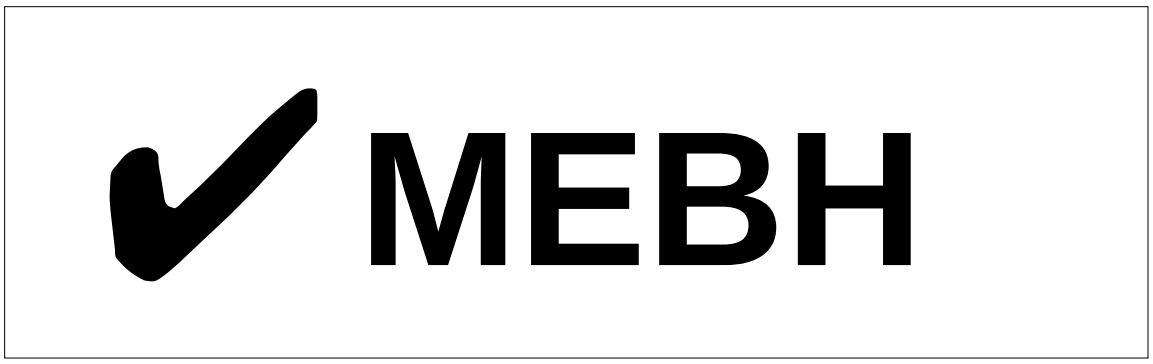
    - The Health Department will notify the case manager when an individual's reimbursement will be decreased and/or when they reach their lifetime maximum.

♦ **When a Covered at Work enrollee reports they have not received their monthly check:**

- Check MEBH to see that the benefit (PC-CW) has been authorized and the mail date of the issuance. The mail date will tell you when the enrollee could expect to received their reimbursement. *Note: see above timelines to determine when the check should have been or will be received.*

- If MEBH does not show an issued benefit and the enrollee is still eligible, authorize the benefit. When the weekly report is received and processed, the check will be sent.

- If authorized and issued and it has not been received by the timelines described above, send the case name and case number via email to Heidi Weaver at hweaver@utah.gov. Heidi will research and send instructions about any needed action or the resolution of the issue.



OPEN ENROLLMENT PERIODS

Section 9

Open Enrollment Periods

PCN enrollment is limited according to the amount of funds available. Therefore, applications are accepted only during open enrollment periods. Open enrollment periods are held when sufficient funds are available.

Note: PCN Covered at Work program has not yet reached it's eligibility participation cap. Accept PCN CW applications on a ongoing basis, not just during open enrollment periods.

♦ PCN Applications Received Outside of Open Enrollment Periods

Use the following procedure when an applicant submits a PCN application form outside of an open enrollment period. This procedure will track the number of PCN applications that are received outside of open enrollment periods, help workers answer customer questions about the status of their PCN application, and verify that applications are reviewed for eligibility for other Medicaid programs.

1. Screen the application for possible Medicaid or Covered At Work eligibility.

2. If it appears the applicant qualifies for Medicaid or Covered at Work, register the appropriate program on PACMIS and determine eligibility.

3. If it appears the applicant does not qualify for Medicaid or Covered At Work, register the PC program on PACMIS.

4. Deny the application using the "OE – NOT AN OPEN ENROLLMENT PERIOD" denial code.

5. Send the MDOE denial notice.

There are certain specific situations an application received outside of an open enrollment period may be approved for PC. Continue with this training section for detailed information.

♦ Applications Received During Open Enrollment

Use the following procedure during PCN open enrollment when reviewing PCN and Medicaid applications, Medicaid closures, and Medicaid reviews.

New PCN Applicants

- An individual must complete and submit an application during the open enrollment period to be considered for PCN enrollment.
    - ▸ Includes individuals residing in households with open Medicaid cases, who are not eligible to be included in the Medicaid coverage because they do not qualify for a Medicaid program.
- Accept any Department approved application form submitted during the open enrollment period. This includes a:
    - ▸ PCN application form
    - ▸ Medicaid application form
    - ▸ DWS application form
- Register applications within 3 working days of receipt by the local office.
- PCN coverage can begin no earlier than the date the application is received.
- Consider PCN for an applicant who has health insurance coverage that will end during the open enrollment period or by the end of the month immediately following the open enrollment period.
    - ▸ The effective date is the 1st day after the coverage ends.

♦ Pending Medicaid Applications

A new application is not required in the following situations. Effective date is the first day of open enrollment.

Consider PCN for any person:

- Included in the household with a Medicaid application that is pending when the open enrollment period begin.
  - ***Example:*** PCN Open Enrollment is Nov. 5 to Nov. 20. Received October 20 Medicaid application for Mother, Father and 2 dependent children. Pended application for requested verifications which were returned on Nov. 10. Looking at Medicaid eligibility you determine the 2 dependent children are NB eligible, however the parents are not Medicaid eligible. Consider PCN eligibility for parents, because Medicaid application was pending when open enrollment began.
- With a DM application (awaiting disability decision) pending when a PCN open enrollment begins.
  - Contact the client to explain PCN and the enrollment fee.
  - ***Example:*** PCN Open Enrollment is Nov. 5 to Nov. 20. Received Sept. 26 application for the Disability Medicaid (DM) program. The applicant's disability needs to be established. All needed medical information and forms are sent to the Medicaid Review Board. When open enrollment began on Nov. 5, you are still awaiting the disability decision from the Medicaid Review Board. Consider PCN eligibility effective Nov. 5 (first day of PCN open enrollment period) while DM decision is pending. Contact the applicant and explain PCN and the enrollment fee. Take proper action on the DM pending application if determined disabled. Close PCN if opening DM.

A new application is not required in the following situations.

Consider PCN coverage when:

- Closing a Medicaid case during the open enrollment period and Medicaid eligibility will end on the last day of the open enrollment month or the month immediately following the open enrollment period.
  - ▸ Begin PCN eligibility the first day of the month immediately following the Medicaid closure.

  Example: PCN Open Enrollment is Nov. 5 to Nov. 20. On Oct. 29 client reported a change but did not provide verifications needed to determine continued eligibility. On Nov. 3 you request verifications. Client provides verifications during PCN open enrollment on Nov. 9. You determine the case is no longer Medicaid eligible and close the Medicaid case effective Nov. 30. Consider PCN effective Dec. 1.

- Medicaid recipient reports a change during an open enrollment period, returns requested verifications by the due date, and the client is no longer Medicaid eligible and Medicaid eligibility ends on the last day of the open enrollment month or the month immediately following the open enrollment period.
  - ▸ Begin PCN eligibility the first day of the month immediately following the Medicaid closure.

  Example: PCN Open Enrollment is Nov. 15 to Nov. 25. Client reported a change during the PCN open enrollment period on Nov. 20 but did not provide verifications needed to determine continued eligibility. On Nov. 24 you request verifications, giving the client 10 days to return them. Client provided the requested verifications timely on Nov. 30. You determine the case is no longer Medicaid eligible and close the Medicaid case effective Dec. 31. Consider PCN effective Jan. 1.

- Individual applies for Medicaid before the open enrollment period and returns all requested verifications by the due date during the open enrollment period and the applicant is not eligible for Medicaid.
  - ▸ PCN effective date is the first day of open enrollment.

  Example: PCN Open Enrollment is Nov.10 to Nov. 20. Client submits an application for Medicaid on Oct. 27. You request needed verifications and client submits them timely on Nov. 15. You work the case eligibility on Nov. 22 and determine the client is not Medicaid eligible. Consider PCN with a Nov. 10 effective date (the first day of PCN open enrollment).

♦ Medicaid Reviews

A new application is not required in the following situations.

Consider PCN eligibility::

- When a review form was received during an open enrollment period **and** the recipient is no longer eligible for Medicaid, **and** Medicaid will be closed by the last day of the open enrollment month or the month immediately following the open enrollment period.
  - ▸ Begin PCN coverage the 1st day of the month immediately following the Medicaid closure.

  Example: PCN Open Enrollment is April 15 to April 25. Client submits a May review and all needed verifications during PCN open enrollment on April 25. You work the review on May 2 and determine the case is no longer Medicaid eligible. You close the case effective May 31. Consider PCN effective June 1.

- When a review form was received before an open enrollment period, **and** the recipient returns requested verifications during the by the due date, **and** you determine during the open enrollment period that the client is no longer eligible for Medicaid, **and** Medicaid will end by the last day of the open enrollment month or the month immediately following the open enrollment period.
  - ▸ Begin PCN coverage the 1st day of the month immediately following the Medicaid closure.

  Example: PCN Open Enrollment is April 15 to April 25. Client submits an April review before PCN open enrollment on April 5. You requested verifications to be returned by April 20. Client provides requested verifications timely on April 18. You work the review on April 25 (the last day of the open enrollment period) and determine the case is no longer Medicaid eligible. Since the case auto-closed April 30, the effective date of the closure will remain April 30. Consider PCN effective May 1.

CHEAT SHEET

COVERED AT WORK REMINDERS

- **General Information:**

  - Applicants who are already enrolled in employer-sponsored health insurance are not eligible for Covered At Work.

  - Payments do not begin and the month should not be authorized as Covered at Work on PACMIS, until the individual verifies they have enrolled in the employer coverage and the date the first premium will be paid. Document these dates on CAAL.

- **Applicants:**

  - When **PCN enrollment is closed**, applicants who have employer-sponsored health insurance available but have to wait for a period of time before they are eligible to enroll, are not eligible for Covered at Work until they can enroll in the employer-sponsored coverage. Follow the steps outlined in the "Steps to Follow When an Applicant Has Access to Employer Sponsored Coverage" memo.

  - When **PCN enrollment is open**, applicants who have employer-sponsored health insurance available but have to wait to enroll in the coverage can be approved for PCN until they are eligible to enroll in the employer-sponsored coverage.

  - Once employer sponsored coverage becomes available:

    - If the cost is less than 5%, the enrollee is not eligible for PCN or Covered at Work. Close the PCN case.

    - If the cost is between 5% and 15% of their gross income, they are eligible only if they choose to enroll in the employer-sponsored coverage. If they choose not to enroll in the coverage, close the PCN case. If they choose to enroll in the coverage, switch them to Covered at Work.

    - If the cost is greater than 15% of their gross income and they choose not to enroll in the employer coverage, they may stay on PCN until the end of the current certification period. At the end of their current certification period, if it is an open enrollment period, and their cost is still greater than 15%, they can choose remain on PCN or enroll in the employer-sponsored coverage and move to Covered at Work.

♦ **Recipients:**

- A PCN enrollee who enrolls in employer-sponsored health insurance, and reports the enrollment within 10 days, can be switched to Covered at Work if their cost of the coverage is more than 5% of their **current** household gross income. If they meet the 5% test, do not redetermine their income eligibility until the end of their current certification period.

- A PCN enrollee who does not report enrollment in employer-sponsored health insurance within 10 days is not eligible for PCN and cannot switch to Covered-at-Work. Close the PCN case. Refer an overpayment for any months that PCN was issued in error.

- PCN enrollees who gain access to employer-sponsored insurance available at a cost more than 5% of their household income, may switch to covered at work if they choose to enroll in the employer-sponsored coverage.

- PCN enrollees who gain access but choose not to enroll in employer insurance, may stay on PCN until the end of the certification period.

- At Review if employer sponsored insurance is still available (even if they have changed jobs):

  - If the cost is less than 5%, or between 5% and 15%, of their household gross income, the enrollee is no longer eligible for PCN. Close the PCN case.

  - If the cost is greater than 15% of their gross income, they may choose to stay on PCN or to enroll in the employer coverage and switch to Covered at Work.